State of Connecticut Nursing Facility PDPM, PDPM Transition and MDS Review Update

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AGENDA

- Overview
- What is PDPM
- Why PDPM
- PDPM Transition Need for Connecticut
- Medicaid PDPM Considerations
- CT PDPM Transition Status
- MDS Documentation Review Overview
- Q&A

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ACRONYMS

- **CMI** - Case-Mix Index; a weight assigned to a specific Resource Utilization Group or an average for a given population that reflects the relative resources predicted to provide care to a resident. The higher the case mix weight, the greater the resource requirements for the resident.

- **MDS** - Minimum Data Set; a core set of screening, clinical and functional elements, including common definitions and coding categories, which form the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare and/or Medicaid.

- **RUG-IV** - Resource Utilization Group, Versions IV; A category-based resident classification system used to classify nursing facility residents into groups based on their characteristics and clinical needs.

- **PDPM** – Patient Driven Payment Model; replaced RUG-IV as the Medicare resident classification system for nursing facility residents as of October 1, 2019.

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NF PAYMENT MODERNIZATION GOALS & OBJECTIVES

- To reflect the Department's overall interest and work in modernizing rates.
- Establish a framework to align with value-based payment in the future.
- Align direct care reimbursement with the anticipated resource needs of each provider based on the acuity of their specific residents.
- Provide incentive for nursing homes to admit and provide care to persons in need of comparatively greater care.

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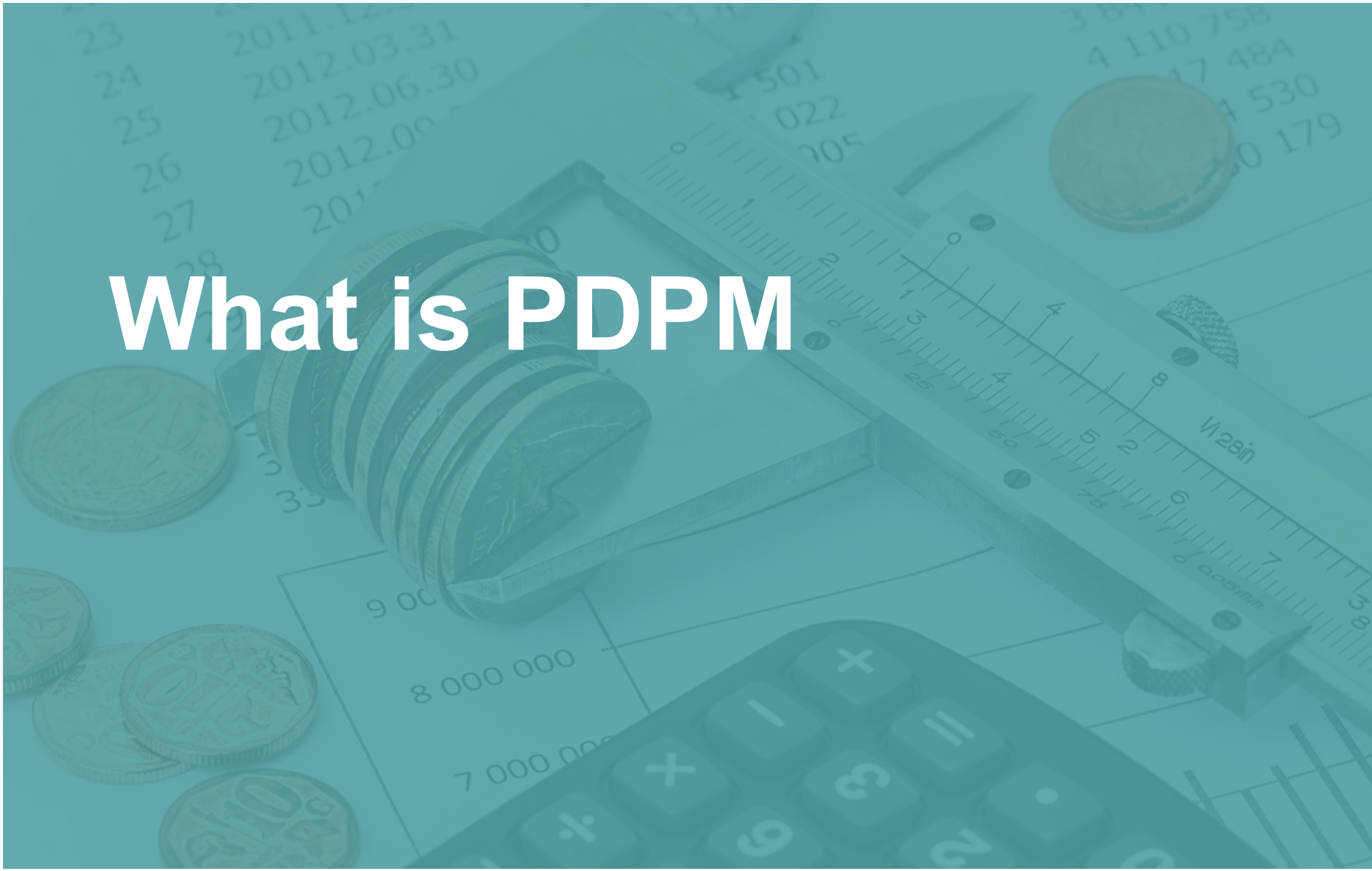
What is PDPM



FY 2019 SNF PPS FINAL RULE (CMS -1696-F)

Major Implication of the final rule:

- Changed the SNF Value-Based Purchasing Program;
- Changed the SNF Quality Reporting Program (QRP); and
- Effective October 1, 2019, required the implementation of the Patient-Driven Payment Model (PDPM) as the replacement for the prior RUG-IV based classification system.

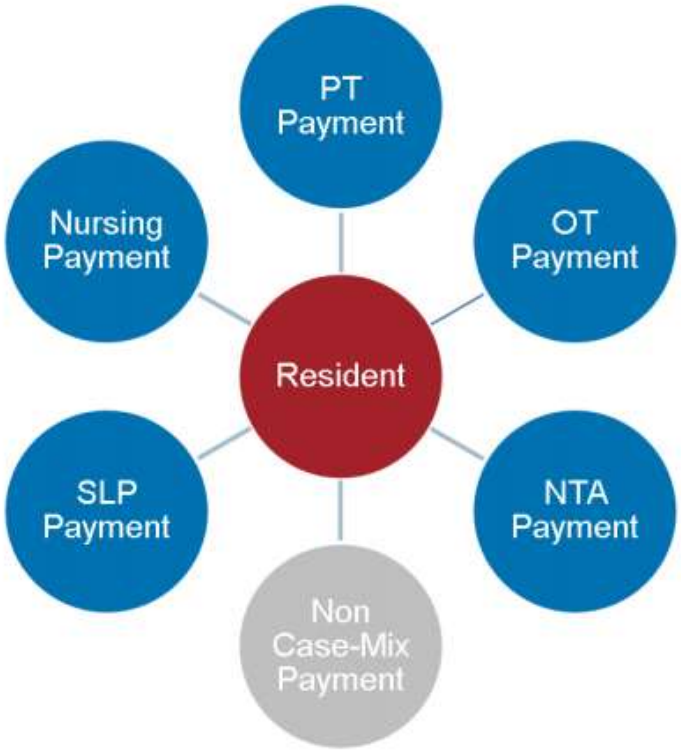
WHAT IS PDPM

- New case mix classification methodology that reimburses for a Medicare stay in a nursing facility based on the **resident's condition** and resulting **care needs**, instead of based merely on volume of services.

- Incorporates 5 individual case mix adjusted rate components and 1 non-case mix adjusted component.

- Focuses on **clinically relevant factors** by using ICD-10 diagnosis codes and other resident characteristics as a basis for classification.

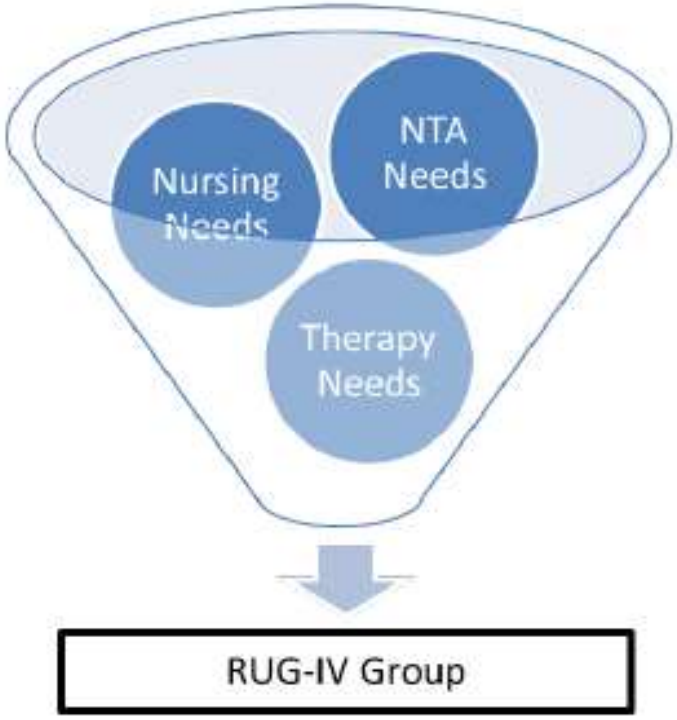
WHAT IS PDPM



**Source: Acumen Skilled Nursing Facility Patient-Driven Payment Model Technical Report (April 2018)*

WHAT IS RUG-IV

- Rate built upon the volume of potential therapy services provided to the resident.
- Rate calculation includes:
  - Two case mix adjusted components: Therapy and Nursing
  - One Non-Case-Mixed Base Rate Component
- Nursing CMI Includes cost of: Nursing, Social Services, and NTA
- Therapy CMI includes cost of: PT, OT, SLP



**Source: Acumen Skilled Nursing Facility Patient-Driven Payment Model Technical Report (April 2018)*

WHAT IS PDPM

Physical Therapy (PT)

- Clinical Category, Functional Score
- Under PDPM, resident characteristics will be used to predict the therapy costs associated with a given resident, rather than rely on service use

Occupational Therapy (OT)

- Clinical Category, Functional Score
- Under PDPM, resident characteristics will be used to predict the therapy costs associated with a given resident, rather than rely on service use

Speech Language Pathology (SLP)

- Presence of Acute Neurologic Condition, SLP-related Comorbidity or Cognitive Impairment, Mechanically-altered Diet, Swallowing Disorder used to predict costs

WHAT IS PDPM

Nursing

- Same characteristics as under RUG-IV, with certain modifications.
- Function score based on Section GG of the MDS 3.0
- Collapsed functional groups, reducing number of nursing groups from 43 to 25.

Non-Therapy Ancillary (NTA)

- NTA Comorbidity Score
- Comorbidities associated with high increases in NTA costs grouped into various point tiers
- Points assigned for each additional comorbidity present, with more points awarded for higher-cost tiers

Variable Per Diem Adjustment

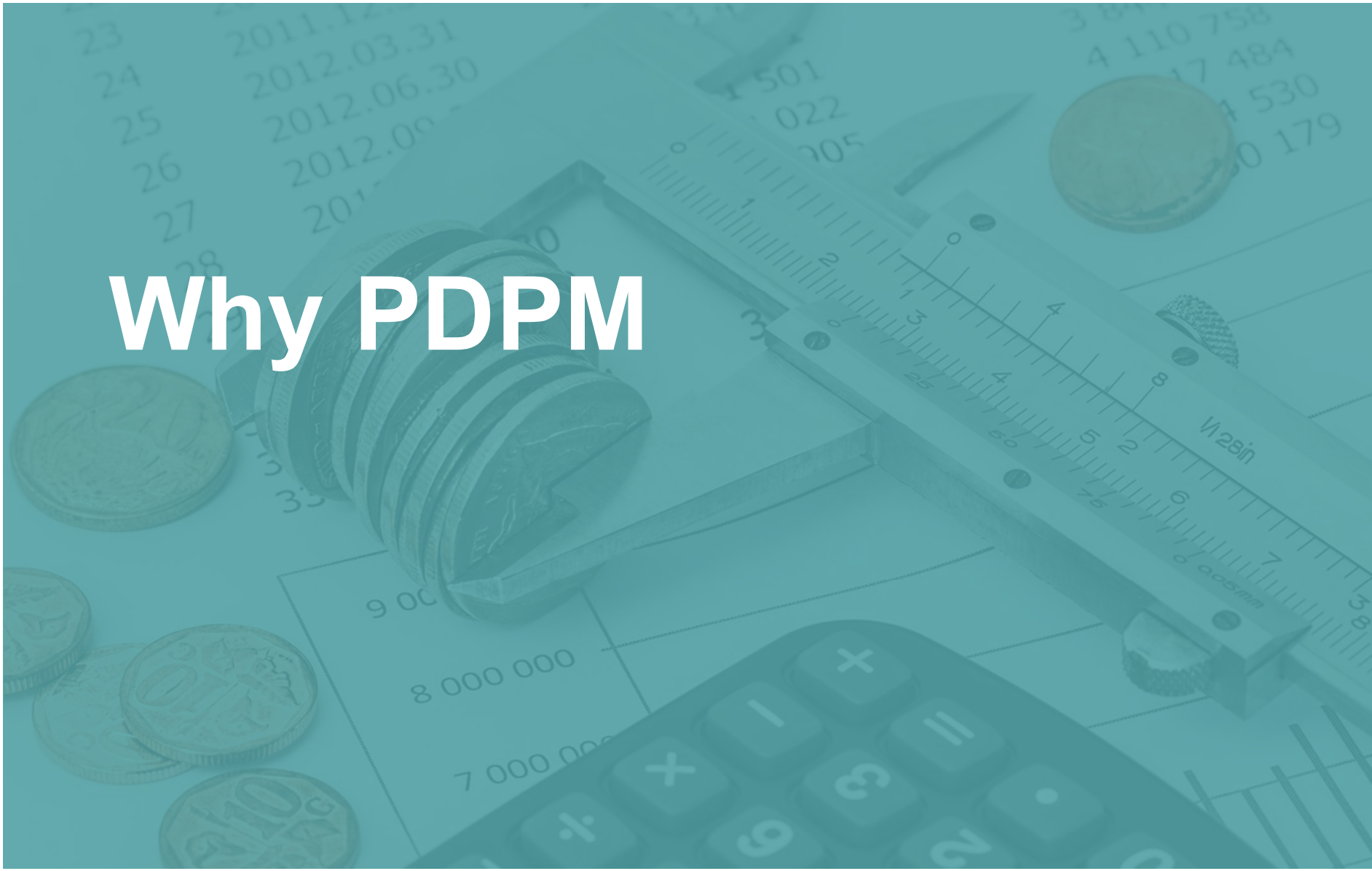
- For the PT, OT, and NTA components, the case-mix adjusted per diem rate is multiplied against the variable per diem adjustment factor, following a schedule of adjustments for each day of the resident's stay

WHAT IS PDPM

PDPM Component Cost Make-Up:

- **PT** – Physical Therapists, therapy aides, therapy supplies
- **OT** – Occupational Therapist, therapy aides, therapy supplies
- **SLP** – Speech Language Pathologist, therapy aides, therapy supplies
- **Nursing** – RN / LPN / CNA / Other Aides / Routine Respiratory / Transportation
- **Non-Therapy Ancillary (NTA)** – Pharmacy / Lab / Radiology / Medical Supplies / Respiratory Therapy / Inhalation Therapy / IV Therapy & Supplies
- **Non- Case Mix** – Room & Board / Capital / Administrative

Why PDPM



WHY PDPM

- Adjusts Medicare payments based on each aspect of a residents care in order to more accurately address costs associated with medically complex residents.
- Focuses resident classifications on the expected needs of the residents rather than the volume of therapeutic services provided.
- Enhances payment accuracy for all SNF services. SNF residents who may have significant differences in terms of nursing needs and costs may receive the same payment for nursing services under a RUG methodology.
- For Medicaid programs, RUG data will be no longer available

PDPM Transition Need for Connecticut

STATE MEDICAID DIRECTOR LETTER SMD #22-005 (9/21/22)

Major Implications for State Medicaid Programs:

- Beginning October 1, 2023, MDS items necessary for RUG-III and RUG-IV based resident classification system are no longer available on the standard MDS item set.
- States wishing to maintain a RUG-based acuity system after October 1, 2023, needed to implement and require submission of an optional state assessment (OSA) as of that date.
- CMS will end date support for use of the OSA by state Medicaid agencies on September 30, 2025.

STATE MEDICAID DIRECTOR LETTER SMD #22-005 (9/21/22)

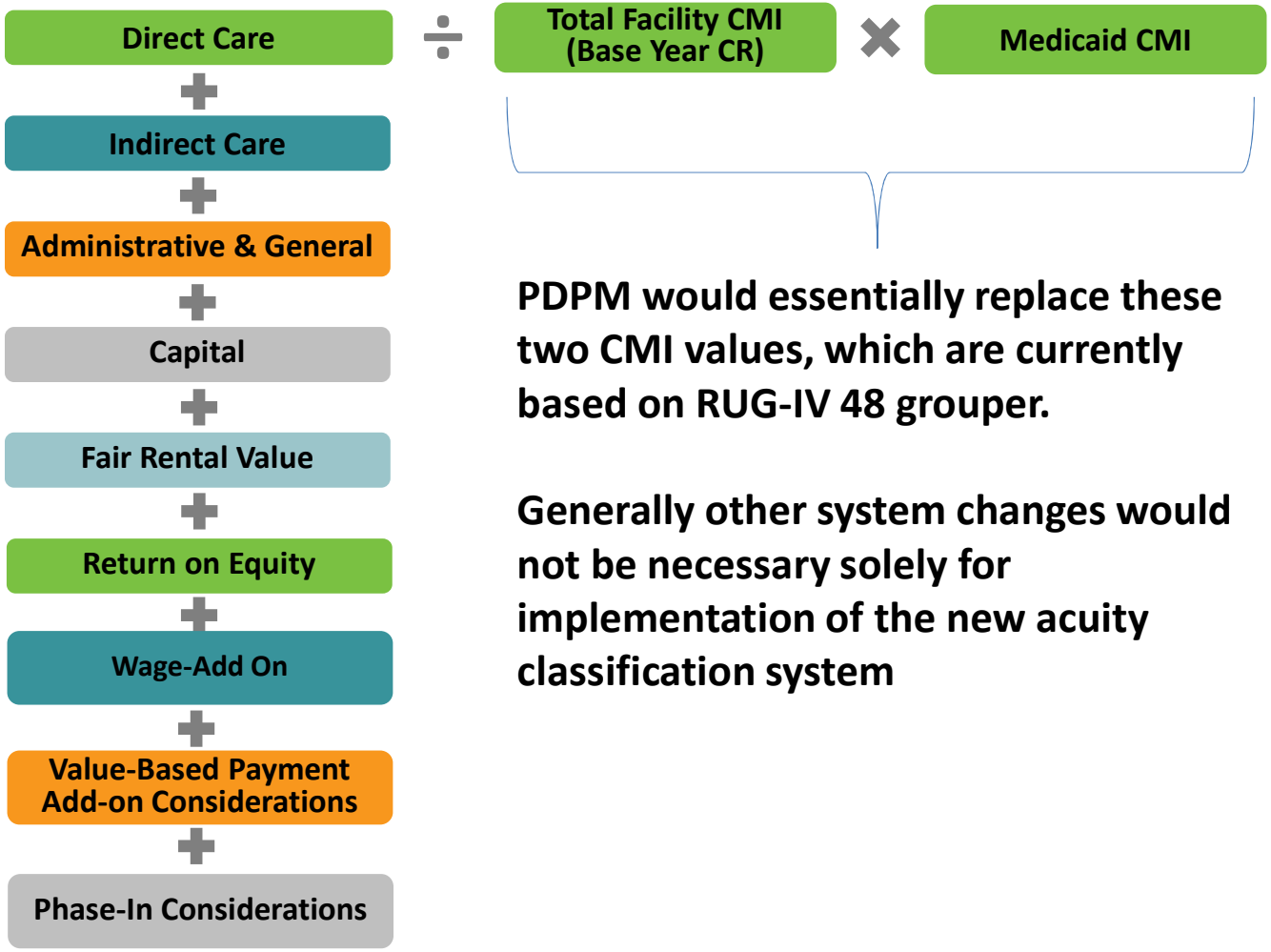
Major Implications for State Medicaid Programs (cont.):

- CMS provided guidance related to the use of a patient-driven payment model (PDPM) approach for required annual upper payment limit (UPL) demonstrations.

CONNECTICUT NURSING FACILITY TRANSITION

- Connecticut currently utilizes the OSA to maintain the RUG-IV based acuity system
- Connecticut can collect OSA data through 9/30/2025
- Connecticut will be able to utilize RUG-IV based MDS data to set rates through 1/1/2026, due to 1 quarter MDS lag inherent to the system
- This sets a preliminary target date for PDPM implementation of 4/1/2026 or 7/1/2026

CASE MIX METHODOLOGY



PDPM would essentially replace these two CMI values, which are currently based on RUG-IV 48 grouper.

Generally other system changes would not be necessary solely for implementation of the new acuity classification system

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DRAFT April 1, 2022 REIMBURSEMENT RATE
(FOR DEMONSTRATION PURPOSES ONLY)
ABC Facility

DISCLAIMER: *Please Note this rate sheet is for demonstration purposes only, and will not be utilized for Medicaid payment/claim adjudication purposes. It is designed to show the potential provider impact from the transition to a case mix (acuity-based) reimbursement system. Facility cost and rate information is subject to change from subsequent audit/review findings, CMI updates, additional legislative changes, and/or further system modification.*

Number:		Actual Resident Days:	20,200
County:		Bed Days Available:	21,900
Geographic Location:	2 - CCNH Non-Fairfield	Occupancy %:	92.24%
Cost Year Begin:	10/1/2018	# Beds:	60
Cost Year End:	9/30/2019		

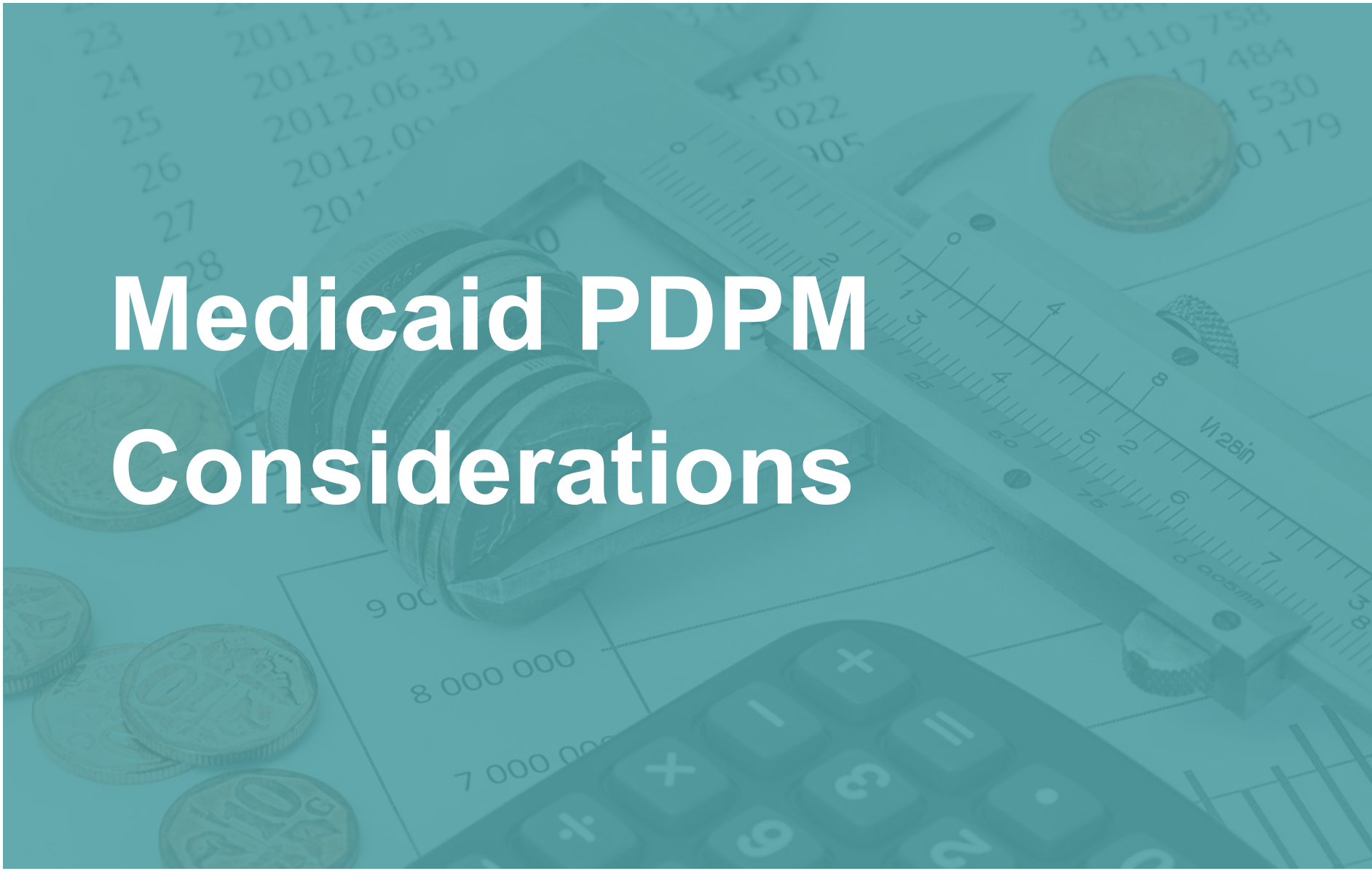
CMI INFORMATION

Quarter Ending	Normalizing (Base Year) CMI	Medicaid CMI	Case Mix Neutrality Factor	Medicaid CMI for Rate Setting
12/31/2021	1.0960	0.9776	100%	0.9776

NET OPERATING

Description	Direct Care	Indirect Care	Admin. & General	Capital/Other	Provider Tax
Facility Costs	$2,487,442	$1,296,050	$1,017,626	$142,153	$333,356
Inflation Multiplier	1.0554	1.0554	1.0554	1.0554	1.0554
Inflated Costs	$2,625,246	$1,367,851	$1,074,002	$150,028	$351,824
Days Used in Division	20,200	20,200	20,200	20,200	20,200
Divided by Days	$129.96	$67.72	$53.17	$7.43	$17.42
Total Facility CMI	1.0960	NA	NA	NA	NA
Cost Per Diem at Total Facility CMI	$118.58	NA	NA	NA	NA
Limit	$171.56	$67.62	$36.82	NA	NA
Allowed Per Diem	$118.58	$67.62	$36.82	$7.43	$17.42
Facility's Medicaid CMI	0.9776	NA	NA	NA	NA
Rate	$115.92	$67.62	$36.82	$7.43	$17.42
Incentive Allowance	NA	$0.00	$0.00	NA	NA
Final Rate	**$115.92**	**$67.62**	**$36.82**	**$7.43**	**$17.42**

Grand Total Net Operating Components **$245.21**



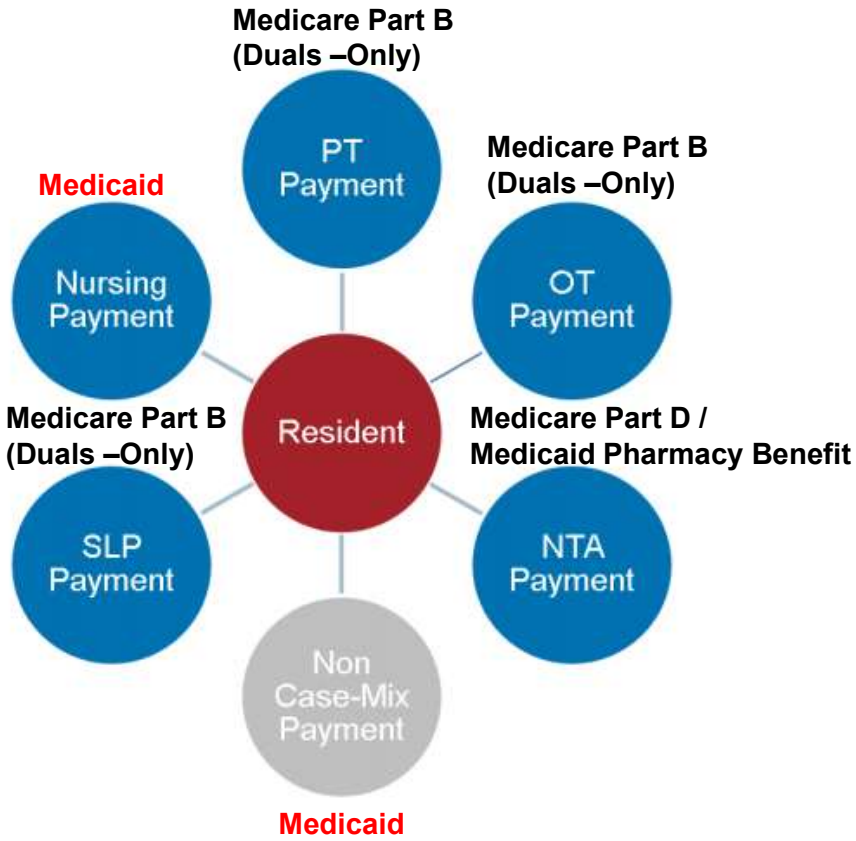
Medicaid PDPM Considerations

MEDICARE AND MEDICAID RATE DIFFERENCES

- Medicare Part A is an all-inclusive rate that pays for generally all aspects of the residents care during their stay

- Medicaid utilizes other coverage benefits to pay for certain services
  - This is particularly pronounced for dual eligible (dual) members.

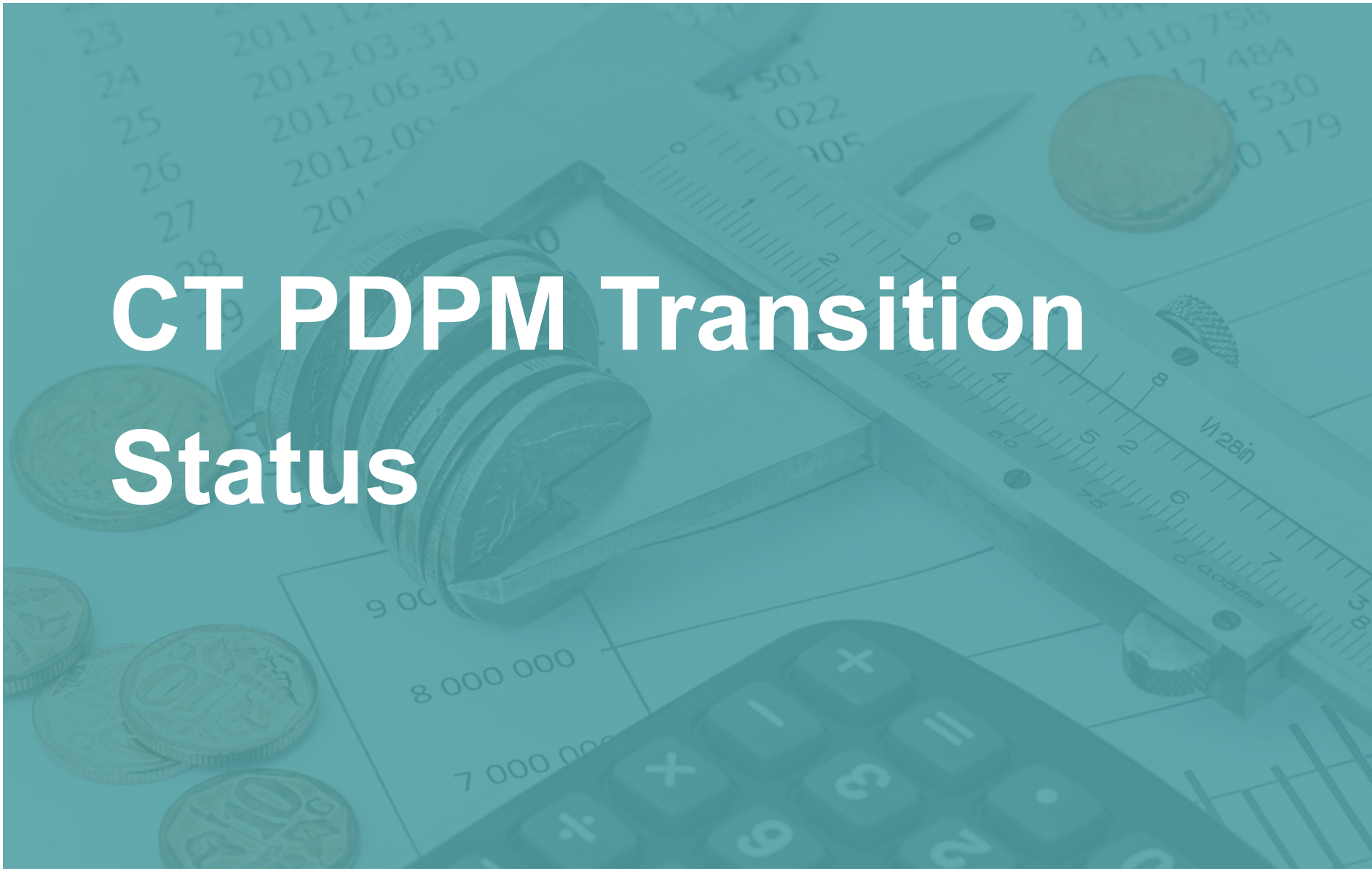
PAYER BY PDPM CATEGORY



HOW HAVE OTHER STATES IMPLEMENTED PDPM

22 states have publicly indicated the PDPM components for their transition. All utilize one of the national weight sets

- 18 states are or will utilize the nursing component of PDPM only to adjust direct care costs
- 1 state utilizes the nursing component for direct care, but the NTA component for non-therapy ancillary costs (med. supplies, etc.)
- 1 state is utilizing a state-specific condensed nursing component for direct care costs and NTA for non-therapy ancillary costs
- 1 state will utilize a blend of Nursing, NTA, and SLP
- 1 state utilizes all PDPM components



CT PDPM Transition Status

CT PDPM TRANSITION STATUS

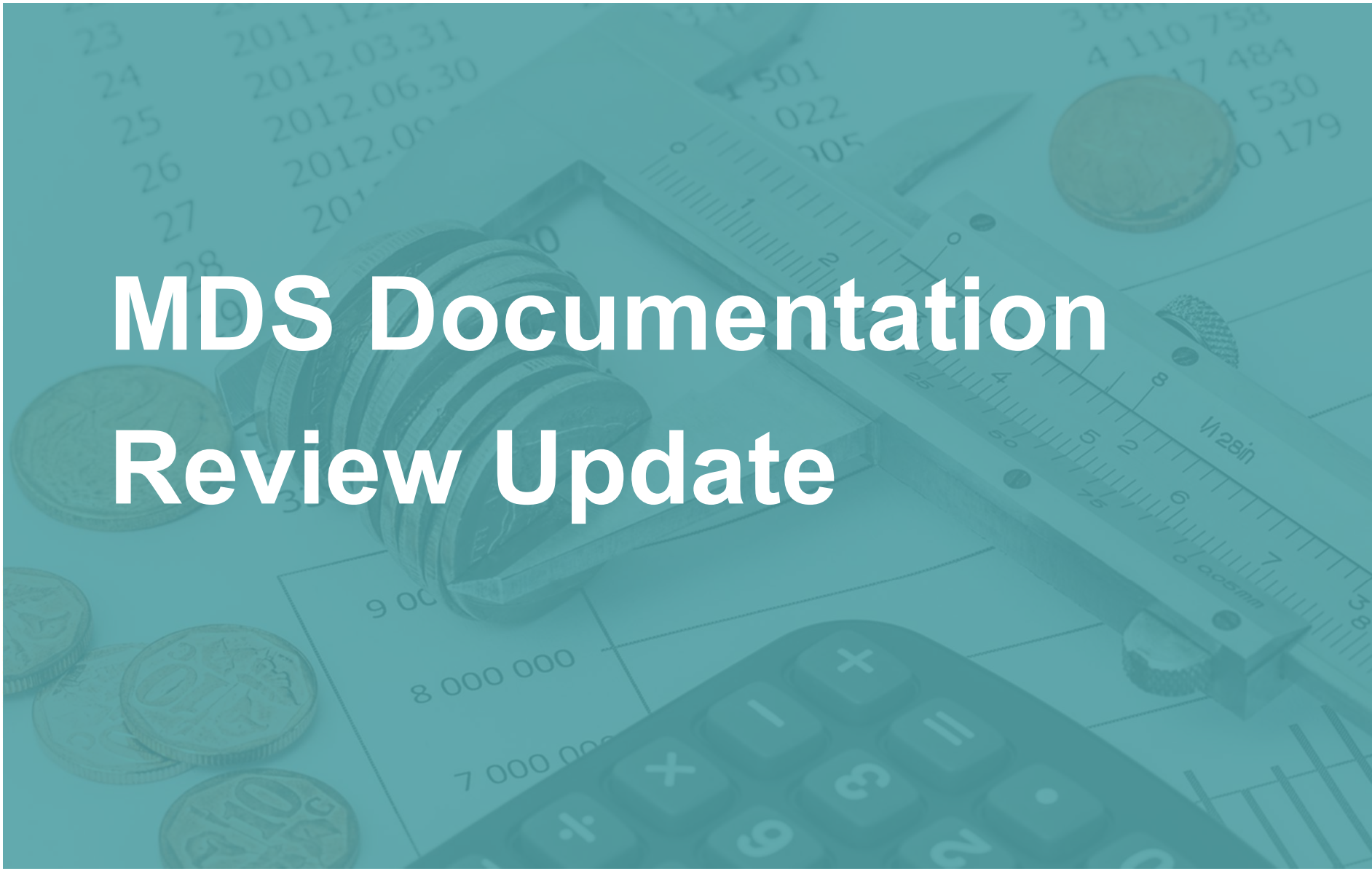
- The evaluation and eventual implementation of PDPM has been a goal of the Connecticut nursing home modernization effort since the first meeting
- Connecticut is in the early stages of gathering the necessary CMI data
- Myers and Stauffer will assist the state in performing analysis on PDPM CMI data and developing rate setting models to see the fiscal impacts of PDPM integration at a statewide and provider specific basis
- As modeling efforts become more complete, more active stakeholder engagement will begin

MAJOR PDPM DECISION POINTS

- PDPM Component Usage for CMI
  - Nursing
  - NTA: Non-Therapy Ancillary
  - SLP: Speech Language Pathology
  - OT: Occupational Therapy
  - PT: Physical Therapy
- PDPM Weight Set to Utilize
  - Data to allow for state specific adjustments is not publicly available

MAJOR PDPM DECISION POINTS

- Treatment of missing PDPM Information
- Establishment of PDPM Shadow Roster period
- Clean-up of historic PDPM periods
- Phase-in considerations
  - Method and timing of phase-in
- System CMI growth thresholds

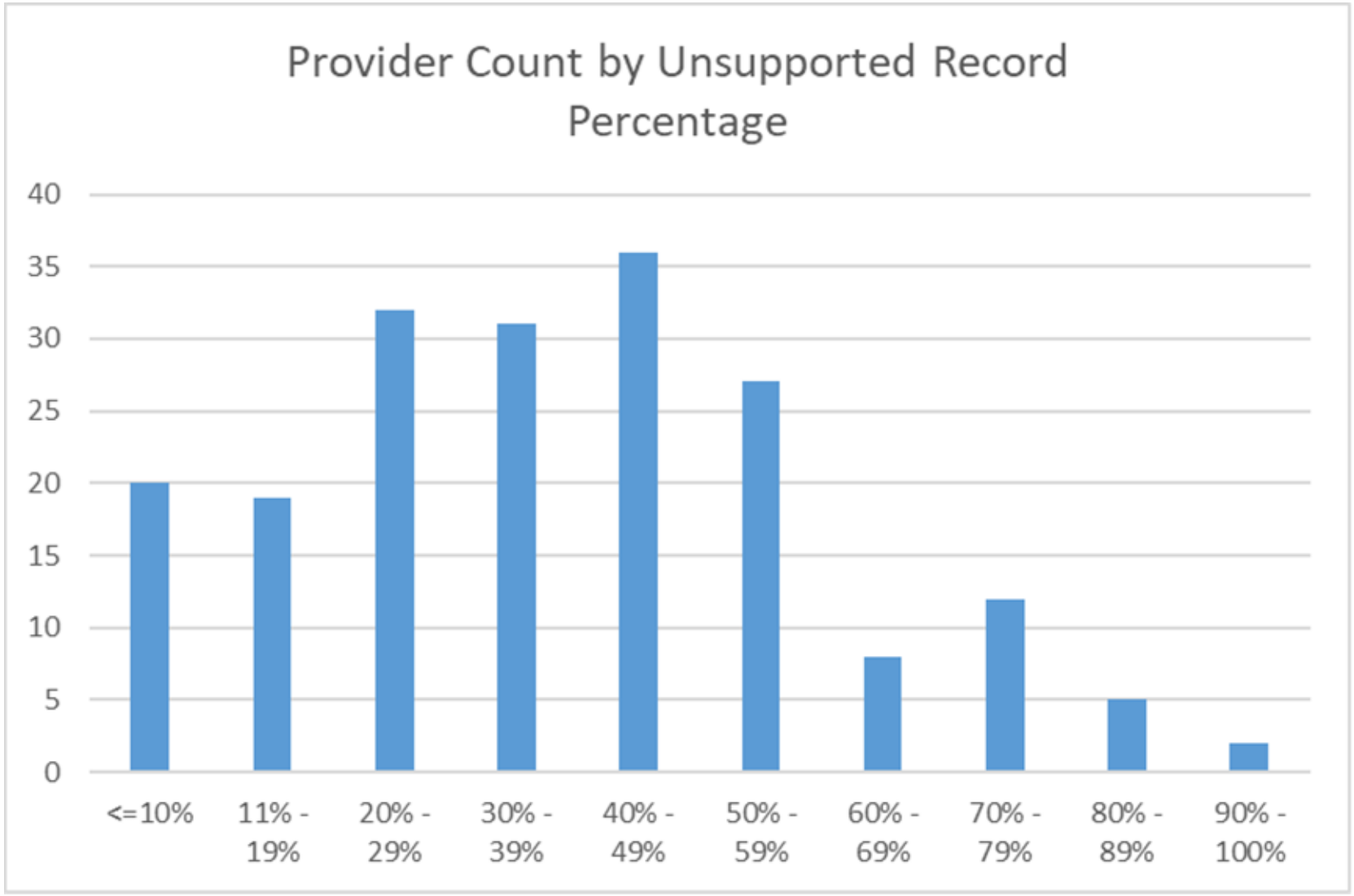


MDS Documentation Review Update

MAJOR PDPM DECISION POINTS

State Fiscal Year 2023 – 2024 Review

- 192 Providers Reviewed
- 172 exceed the review expansion threshold
- 20 were at or below the expansion threshold


Provider Count by Unsupported Record Percentage
40
35
30
25
20
15
10
5
0
<=10%
11% - 19%
20% - 29%
30% - 39%
40% - 49%
50% - 59%
60% - 69%
70% - 79%
80% - 89%
90% - 100%

MOST COMMON REVIEW FINDINGS

- ADL's
- BIMS & PHQ-9 Interviews
- Diagnosis-Pneumonia, Septicemia, Hemiplegia, COPD, Respiratory Failure
- Isolation
- Proportion of calories via feeding tube

PDPM IMPLICATIONS FOR MDS REVIEWS

- Supportive Documentation Requirements will be updated based on the components of PDPM selected for use in CT
- These will be updated and released to providers in advance of PDPM implementation

QUESTIONS?